

Orthopaedic Surgery Associates

O F M A R Q U E T T E P C

1414 W. Fair Avenue, Suite 190
Marquette, Michigan 49855
906-225-1321; Fax 906-225-3968
www.osamqt.com

CONSULTATION REQUEST FORM

Please fax completed form to 906-225-3968

Patient Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Insurance Coverage/Carrier:		
Consultation defined: Requesting provider is seeking advice or opinion on a specific problem and is not transferring all or a portion of the patient's care as identified below.		
<i>Circle appropriate priority of request below – Routine, Urgent or Emergent</i>		
<input type="radio"/> Routine – Patient will be contacted within 72 hours for appointment	<input type="radio"/> Urgent – Patient will be contacted within 24 hours for appointment	<input type="radio"/> Emergent – Call Office
CLINICAL INFORMATION		
Diagnosis/Symptoms:		
Type of Injury (<i>if applicable</i>): ___ Work Injury ___ Auto Injury ___ Other Injury		
If "Other Injury", please specify:		Date of Injury:
Off Work Due to Illness? <input type="radio"/> Yes <input type="radio"/> No		
<i>If any prior treatments/surgery for this condition, please submit all records, notes, images, operative reports and test results by mail or fax, as appropriate</i>		
Referring Physician Name:		Phone:
Form Prepared By:		Fax:

PLEASE NOTIFY REQUESTING PHYSICIAN OF APPOINTMENT

Appointment Date: _____ Time: _____		Office Location:
Provider Name:		Date Patient Contacted:
Date: _____ Initials: _____	Contact Person:	